

Transitional Housing for Women Referral Form



TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion and all other identities represented in our community.

TeamHEALTH provides Transitional Housing for Women and children experiencing, or at risk of, homelessness, including those impacted by domestic and family violence. The program has been designed to support healing, recovery and wellbeing. Alongside accommodation, residents receive personalised support to help them connect with services, develop goals, strengthen their wellbeing, and work towards sustainable housing outcomes.

Participant Details

Participants' Name: _____ Preferred Name: _____

Date of Birth: _____ Country of Birth: _____

Gender identity: ☐ Woman ☐ Man ☐ Non-binary
☐ Different term – please specify: _____

Pronouns (optional): _____

Address: _____

Email Address: _____ Phone Number: _____

Preferred contact method: ☐ Call ☐ Text ☐ Email

Preferred language: _____

(The language the participant feels most comfortable using)

Interpreter needed? ☐ No ☐ Yes If yes, what language? _____

Any other language or communication supports needed? ☐ No ☐ Yes

If yes, please describe: _____

(For example: Auslan, large print, a communication device, or a support person)

Is the participant of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Public Guardian in Place? ☐ Yes ☐ No Name & Phone Number: _____

Carer in Place? ☐ Yes ☐ No Name & Phone Number: _____

Child Protection Orders in Place? ☐ Yes ☐ No If yes, please attach details. _____

Emergency Contact/Next of Kin: Name & Relationship: _____

Phone Number: _____

Referral Details

Person Referring: _____

Referral Details

Relationship to Participant: _____

Phone Number: _____

Email: _____

Referrer's Signature: _____ Date: _____

Accompanying Children

Please list each child/young person and their date of birth. We ask about gender only for children aged 14 or older, because our accommodation can't support males in that age group.

Child/Young Person 1 Name: _____

Is the child/young person of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Gender identity: _____ Date of Birth: _____

(How the child or young person identifies, or is describe by their caregiver)

Pronouns (optional): _____

For those aged 14 and over, please describe their gender: _____

Child/Young Person 2 Name: _____

Is the child/young person of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Gender identity: _____ Date of Birth: _____

(How the child or young person identifies, or is describe by their caregiver)

Pronouns (optional): _____

For those aged 14 and over, please describe their gender: _____

Child/Young Person 3 Name: _____

Is the child/young person of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Gender identity: _____ Date of Birth: _____

(How the child or young person identifies, or is describe by their caregiver)

Pronouns (optional): _____

For those aged 14 and over, please describe their gender:

Eligibility Criteria	
Participant is a woman and aged 18+	☐ No ☐ Yes
Transitional Housing The participant and any accompanying children require transitional accommodation due to experiencing or being at risk of homelessness, including those impacted by family and domestic violence.	☐ No ☐ Yes
Residing in Katherine The participant and any accompanying children are located in or relocating to the Katherine and Big Rivers region.	☐ No ☐ Yes
Capacity to reside in transitional accommodation The women and children can live securely in supported accommodation (business hours only) and do not have immediate risks that cannot be managed on-site (e.g. unmanaged violent behaviours, high-risk perpetrator pursuit, acute medical needs).	☐ No ☐ Yes
Voluntary engagement The woman consent to the referral and is willing to engage in case planning and safety planning.	☐ No ☐ Yes
Children residing must be in participant care and attending school if of school age Children accompanying the woman must be in her care, and their wellbeing can be supported on-site.	☐ No ☐ Yes

Our service is not equipped to support with the following scenarios, and we suggest an onwards referral to specialist or crisis services if the following are current or present:

- Requires emergency relocation
- Has a current threat from the perpetrator
- Has recent or current severe violence events with ongoing risk
- Has active substance-related behaviour that may disrupt safety
- Requires secure refuge conditions
- If there are children in the care of the participant that are male and 14 years or over. There may be exceptions to this in extenuating circumstances.

Reason for Referral

Please outline the applicant's current situation (housing status, financial, dependent children, leaving mental health or correction facility, etc)

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Please note any known history or current Domestic and Family Violence (If any DFV history, please provide DFV Safety plan and Risk Assessment (CRAT preferred) if available, DVO, PVRO etc):

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Identified Support Needs and Existing Supports	
Ladybird House staff do not provide all of these supports but can make referrals, as required.	
Domestic and Family Violence	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by:
Child & Family wellbeing	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by:
Mental health support	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by:
Alcohol and other drug (AOD) support	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by: History of withdrawal, relapses, or treatment? ☐ Yes ☐ No
Physical health/medical supports	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by:
Disability supports	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by:
Budgeting, tenancy, employment or Centrelink	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by:
Cultural connection	☐ No support needed ☐ Support needed, currently unsupported ☐ Currently supported by:

Risk Assessment (Referrer to complete)

TeamHEALTH requires a brief participant risk assessment to ensure that we understand how to keep our staff, participants and community safe. If you are completing a self-referral and need assistance filling out a risk assessment, please call us on the phone number below.

Participant risk factors

If selecting yes to any of the below, please expand on or attach relevant information/documentation prior to completion of the referral.

Yes**No**

History of suicide attempt/s or current suicidal ideation (e.g. chronic, recent):

☐☐

Please provide further details:

History of self-harm (e.g. chronic, recent):

☐☐

Please provide further details:

Recent traumatic life event (e.g. assault, bereavement, legal concerns, family violence, homelessness etc.):

☐☐

Please provide further details:

Historical or current drugs or alcohol use:

☐☐

If yes, please provide details of substances and any history of rehab or AOD counselling:

Forensic history (including DVO, custodial order, recent incarceration, upcoming legal matters, parole or bail conditions:

☐☐

Please provide further details:

Currently under Community Corrections supervision?

☐☐

Please provide further details:

Any known violent or property offences relevant to shared living?

☐☐

Please provide further details:

Recent known incident involving aggression/violence/weapon use or possession, incl. family member with DVO:

☐☐

Please provide further details:

Expressing intent to harm others/preoccupation/hallucinations with violent or paranoid themes/ideas:	☐	☐
Please provide further details:		
Vulnerabilities (financial abuse, trauma history, relational/sexual):	☐	☐
Please provide further details:		
Known DFV perpetrator risks to participant, staff or neighbours?	☐	☐
If yes, please provide further details:		

Protective factors (e.g. friends, professional relationships, culture, faith, hobbies, study, employment etc.)

Recommendations to support the safety and comfort of the person in our service (e.g. safety plans, coping strategies, skills or strengths)

Supporting Documentation

Providing as many of these as are applicable will increase the speed with which this referral will be processed.

Domestic and Family Violence:

- ☐ Relevant case notes
- ☐ Risk assessment (Common Risk Assessment Tool preferred)
- ☐ Domestic and Family Violence Safety Plan

Child and Family Wellbeing:

- ☐ A non-custodial supervision order on any accompanying children
- ☐ Child welfare orders

Physical and/or Mental health:

Supporting Documentation

- ☐ Behaviour Support Plan
- ☐ Community Management Order
- ☐ Mental Health Safety Plan

- ☐ Mental Health Risk Assessment
- ☐ NDIS Plan
- ☐ Medication Chart

Consent

TeamHEALTH is collecting this information to set up and provide your support. We'll store it securely and only share it where it's needed to arrange or deliver that support. You can ask to see or correct your information, or withdraw your consent, at any time. This won't affect the support you receive.

☐ I consent to this referral

Your information is handled in line with the *Privacy Act 1988 (Commonwealth)*, the *Australian Privacy Principles*, and the *NT Information Act*.

Signature of Participant

Signature of Public Guardian (if applicable)

Date

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Completing this Form

- Please call TeamHEALTH on **1300 780 081** if you need any assistance completing this form.
- Send the completed form to: teamhealth@teamhealth.asn.au.
- TeamHEALTH will contact the participant or Public Guardian within three working days of receiving this form.

Thank you for your referral!